tive of widowed individuals in the sampled region. There is no basis for assuming that study participants would provide more support for the stage theory than study nonparticipants. Because we sought to focus on the normative rather than extreme responses to loss, we removed cases of prolonged grief disorder, and excluded cognitively impaired individuals. By "normal" we refer to the statistical norm (or average) bereavement response, not to a subjective judgment of what is or is not normal. As Dr Weiner notes, replication in other contexts (traumatic modes of death, different cultures) is needed.

Silver and Wortman claim that our data were not analyzed longitudinally and that our analytic strategy would mask within-participant fluctuation in response over time. However, the data were analyzed longitudinally (Table 2 in our article). In addition, the regression models included time from loss as an independent variable. Consequently, time was factored into the analyses; the analyses were not cross-sectional. Silver and Wortman also are concerned that the analyses would inflate apparent across-time differences. However, random selection of observations in the regression analyses served to remove bias and dependence between observations, thereby generating unbiased results.

Drs Bonanno and Boerner state that single-item indicators represent a methodological flaw because these items were unreliable. However, these items have been evaluated and found to be among the most informative and unbiased in the evaluation of prolonged grief disorder.[2] The assertion by Bonanno and Boerner that the stage model "lacks explanatory value" belies the fact that it predicts the sequence of peaks that emerged from the data. Nevertheless, we agree that the finding that acceptance is the most commonly reported response (even soon after the death) lends support to research indicating that most bereaved individuals show great resilience in the face of loss. Understanding of normative responses to loss requires careful empirical study. Although the results reveal some discrepancies with the theory, they suggest that stages of grief remain an important construct for understanding bereavement.

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1. National Cancer Institute Web site. Loss, grief and bereavement. http://www.nci.nih.gov/cancertopics/pdq/supportivecare/bereavement/Patient/page6. Accessed April 9, 2007.
2. Prigerson HG, Vanderwerker LC, Maciejewski PK. A case for inclusion in DSM-V. In: Stroebe M, Hansson R, Schut H, Stroebe W, eds. *Handbook of Bereavement Research and Practice: 21st Century Perspectives*. Washington, DC: American Psychological Association Press. In press.

Posttraumatic Stress Disorder and Cognitive Behavioral Therapy

To the Editor: In their study of the treatment of women with posttraumatic stress disorder (PTSD), Dr Schnurr and colleagues[1] reported the superiority of prolonged exposure over present-centered therapy. We believe that their use of present-centered therapy as a comparison group is problematic.

Present-centered therapy was described as "clinically relevant" and as a "control for the nonspecific benefits of therapy." Present-centered therapy was used so that the effects of prolonged exposure could be attributed to prolonged exposure rather than the purported "benefits of good therapy." Present-centered therapy, however, did not appear to represent a bona fide therapy. The treatment was described as primarily involving discussion and review of "general daily difficulties," specifically prohibiting any exposure or cognitive restructuring. Their methods article discusses present-centered therapy in more detail, stating that if the patient mentions "trauma-related issues, the therapist gently redirects her to discuss other material."[2]

It is difficult to understand how a therapy for PTSD that forbids all discussion of trauma-related material can be considered fully therapeutic, as trauma is a core component of the disorder. Indeed, present-centered therapy seems to more accurately resemble a weak placebo intervention than a bona fide psychotherapy. Its description does not reference any established approach to psychotherapy. It appears to not be based on any psychological process, to prohibit discussion of relevant issues, and to contain no active ingredient (eg, exposure, addressing recurring relationship patterns). Interventions that lack such ingredients generally perform worse than therapies that are fully intended to be therapeutic.[3,4]

The authors state that present-centered therapy is typically used for women in the Department of Veterans Affairs (VA) system with PTSD.[5] However, while in the current trial present-centered therapy was delivered according to a manual, less than 10% of VA therapists use treatments according to a manual.[5] Many VA practitioners at least occasionally use exposure techniques and restructuring of trauma-related thoughts, both of which were forbidden in the present-centered therapy manual.[5] An estimated 70% to 80% of VA clinicians use coping skills training during their treatment of PTSD patients,[5] while the present-centered therapy used by Schnurr et al contains no reference to any skill-building component.

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1. Schnurr PP, Friedman M, Engel C, et al. Cognitive behavioral therapy for posttraumatic stress disorder in women. *JAMA*. 2007;297:820-830.
2. Schnurr PP, Friedman MJ, Engel CC, et al. Issues in the design of multisite clinical trials of psychotherapy. *Contemp Clin Trials*. 2005;26:626-636.
3. Wampold BE, Minami T, Baskin T, et al. A meta-(re)analysis of the effects of cognitive therapy versus "other therapies" for depression. *J Affect Disord*. 2002; 68:159-165.
4. Baskin TW, Tierney S, Minami T, et al. Establishing specificity in psychotherapy. *J Consult Clin Psychol*. 2003;71:973-979.
5. Rosen CS, Chow H, Finney J, et al. VA practice patterns and practice guidelines for treating posttraumatic stress disorder. *J Trauma Stress*. 2004;17:213-222.

In Reply: Psychotherapy research is challenging because of the absence of simple placebos used in medication trials. In response to Dr Spielmans and Ms Gatlin, all psychotherapies contain nonspecific elements that occur within the context of a positive psychotherapeutic relationship, including emotional support, decreased isolation, mobilization of hope, and an increased sense of mastery.[1] Controlling for these factors when studying the effects of a particular treatment is essential to determine whether there are specific effects of that treatment beyond the effects of these often-powerful elements. This was the intent of present-centered therapy. Thus, Spielmans and Gatlin are correct in saying that present-centered therapy did not specifically reference any established therapeutic approach, although we note that present-centered therapy contained elements of supportive therapy, one of the most commonly practiced treatments.[2]

However, other aspects of their characterization are incorrect. Present-centered therapy was based on psychological process, allowed discussion of relevant issues (current problems), and contained active ingredients. Present-centered therapy included psychoeducation about responses to trauma, normalizing these responses, and increasing insight into their influence on current problems. The broad goals were to use the therapeutic relationship to increase a sense of connection and to use problem-solving strategies to increase a sense of mastery. Therapists could use a range of supportive and insight-oriented interventions.

Trauma focus was not merely avoided. Patients were provided with a rationale for the present focus in a manner equivalent to the provision of a trauma-focused rationale in prolonged exposure. Therapists who delivered present-centered therapy fully acknowledged and validated each patient's trauma history and the painful consequences of having experienced trauma. Achieving greater insight and support around the consequences of trauma was a key ingredient in present-centered therapy. Based on reports of present-centered therapy supervisors (who viewed therapy sessions on videotape), the need to redirect patients from discussing trauma occurred infrequently and did not pose difficulties.

Patients found present-centered therapy to be credible. Present-centered therapy and prolonged exposure patients had comparable ratings on a measure of expectancy of therapeutic outcome. Average ratings on a 0 (not at all) to 8 (extremely) scale were 6.8 in present-centered therapy and 6.6 in prolonged exposure for how logical the treatment seemed, and 5.6 in both groups for expectations that the treatment would reduce trauma-related symptoms. Patients also liked present-centered therapy. Treatment satisfaction was high in both groups. Dropout was significantly lower in present-centered therapy than in prolonged exposure. Furthermore, present-centered therapy led to an improvement of 22.8% on our primary PTSD measure. Although prolonged exposure led to even greater improvement—31.8%—program evaluation data show improvements of 5% or less following a comparable amount of treatment in VA women's PTSD programs.[3]

Whether explicitly focusing on traumatic experiences is necessary for treating trauma survivors is not a settled issue. Stress inoculation[4] and interpersonal therapy[5] (which, like present-centered therapy, addresses current social and interpersonal difficulties) are among the viable alternatives that do not focus on trauma. Within this context, present-centered therapy was much more than a placebo—it served as a credible but nonspecific comparison treatment.

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1. Rosenthal D, Frank JD. Psychotherapy and the placebo effect. *Psychol Bull*. 1956;53:294-302.
2. Pingitore D, Scheffler RM, Haley M, et al. Professional psychology in a new era: practice-based evidence from California. *Prof Psychol Res Pr*. 2001;32:585-596.
3. Fontana A, Rosenheck R. *Women Under Stress II: Evaluation of the Clinical Performance of the Department of Veterans Affairs Women's Stress Disorder Treatment Teams.* West Haven, Conn: VA Northeast Program Evaluation Center and National Center for PTSD; 2002.
4. Foa EB, Dançu CV, Hembree EA, et al. A comparison of exposure therapy, stress inoculation training, and their combination for reducing posttraumatic stress disorder in female assault victims. *J Consult Clin Psychol*. 1999;67:194-200.
5. Bleiberg KL, Markowitz JC. A pilot study of interpersonal psychotherapy for posttraumatic stress disorder. *Am J Psychiatry*. 2005;162:181-183.